Medicaid Information Bulletin

October 2004

Web address: http://health.utah.gov/medicaid

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BULLETINS BY TYPE OF SERVICE

On-Line (Internet) Address for Medicaid:

http://health.utah.gov/medicaid

Please make sure that any Medicaid bookmarks that you have are the new Medicaid Internet address shown above. The old web site is not being kept up to date, and it will be discontinued in late 2004. The old Medicaid Internet address was printed in many Medicaid documents. The address will be corrected when the document is updated.

World Wide Web: http://health.utah.gov/medicaid (Formerly http://www.health.state.ut.us/medicaid)

Medicaid Information

- **Salt Lake City area, call 538-6155.**
- **In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona and Nevada, call toll-free 1-800-662-9651.**
- **From other states, call 1-801-538-6155.**

Requesting a Medicaid publication?

Send a Publication Request Form.

- **by FAX: 1-801-536-0476**
- **by mail to: Division Of Health Care Financing Box 143106, Salt Lake City UT 84114-3106**

04 - 78 HIPAA Format for Professional Claims Submission

Effective October 15, 2004, Medicaid accepts electronic professional claims in the 4010 837P format. If you are utilizing the old 3032 format, please transition to the HIPAA compliant format as soon as possible.

All 4010 837 professional claims will be processed in production. When first using the new format, please submit a small claim volume to verify that claims processing is uninterrupted and payment is received as expected. ☐

04 - 79 Professional Claim Corrections Through Re-submission

In an effort to provide better customer service for claims corrections, Medicaid will use the claim form as a means of processing claim corrections. Effective November 1, 2004, providers who use the 837P for electronic claims submission or CMS1500 may utilize this process. Institutional and dental formats are under development. Information to follow in future bulletins.

The following data elements are required to identify the claim as a replacement or void of an original claim:

Claim Frequency Code
Acceptable values: 6 or 7 for replacement, 8 for void
Electronic: X12 element 2300 CLM05-3
Paper: UB92 - Form Locator 4, position 3
CMS1500 - Box 22 (Code)
Dental - Process not available on paper.

Original Reference Number
Transaction Control Number (TCN) of original claim to be replaced or voided
Electronic: X12 element 2300 REF02
Paper: UB92 - Form Locator 37 A-C (same line as Medicaid in 50A-C)
CMS1500 - Box 22 (Original Ref. No.)
Dental - Process not available on paper.

Replacement claims will void the original claim and process the replacement claim. Please consult with your programmer to verify the required data elements are available in your software. Claims submitted without a valid original reference number (TCN) will be denied.

When first using the new process, please submit a small claim volume to verify that claims processing is uninterrupted and corrections/voids are processed as expected. ☐

04 - 80 Copayment Changes

Beginning October 1, 2004, a $3 copayment per visit will be deducted for Medicaid payments made for claims paid for services rendered by nurse practitioners. This will make all physician services have a standard $3 per visit copayment requirement, whether provided by physicians, physician assistants or nurse practitioners. If the Medicaid card indicates copayment required, $3 per visit should be collected from the Medicaid recipient for physician services. ☐

04 - 81 Occupational Therapy

The correct billing code for occupational therapy evaluations and therapy is T1015, clinic visit encounter, billed with a GO modifier. All visits after the initial first ten visits require prior authorization. This applies to treatments by occupational therapists done as an Independent practice or in a Rehab PT/OT clinic. ☐

04 - 82 Oral Surgery Manual Correction

D5931, Surgical Obturator, is only open to dentists in conjunction with cleft palate surgical cases done at Primary Children's Hospital's Cleft Palate Clinic. ☐

04 - 83 Speech and Language

92526, Treatment of swallowing dysfunction and /or oral function for feeding, is added to the Speech and Language Manual with a written prior authorization requirement.
92610, Evaluation of oral & pharyngeal swallowing function, was listed in error as requiring a prior authorization. No prior authorization is required.

Opened codes

E2504, Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time. Requires prior authorization.

E2506, Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes but less than or equal to 60 minutes recording time. Requires priors authorization.

Speech generating device codes, E2502-E2510, are now priced at a 15% discount from the Medicare allowable reimbursement for this region. ☐

04 - 84 Aging Waiver Provider

An updated manual has been published for the Medicaid 1915c Home and Community-Based Services Waiver for Individuals Age 65 and Older (Aging Waiver). The replacement manual provides information consistent with the July 1, 2004 amended version of the Waiver Implementation Plan approved by the Centers for Medicare and Medicaid Services.
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04 - 85 Acquired Brain Injury Waiver Provider Manual

An updated manual has been published for the Medicaid 1915c Home and Community-Based Services Waiver for Individuals with Acquired Brain Injuries (ABI Waiver). The replacement manual provides information consistent with the July 1, 2004 version of the Waiver Implementation Plan approved by the Centers for Medicare and Medicaid Services.
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04 - 86 Home Health Agencies San Juan and Grand Counties Exception

To assure continued access to home health services for residents of San Juan county and Grand counties, enhancements in home health reimbursement rates are provided. Effective April 1, 2004, for services provided in San Juan County and Grand County, the home health fee schedule is multiplied by 2.03 and 1.77 respectively to calculate the payment rate for applicable service codes. These enhancement factors are applied irrespective of the distances traveled to provide these services and are in lieu of the rural area exceptions provided for other rural counties. ☐

04 - 87 Child Health Evaluation and Care Manual Updated

We have updated the Utah Medicaid Provider Manual for Child Health Evaluation and Care Program (CHEC) Services as follows:

Appendix D - Lead Toxicity Risk Assessment

We have deleted the year 1960 and added the year 1978 in question 2, **"Does your child live in a house built before ~~1960~~ 1978 with recent, ongoing or planned renovation or remodeling?"**

The revised Appendix D is on the Internet. The link to the CHEC Manual is www.health.state.ut.us/medicaid. If you do not have Internet access, contact Medicaid Information for a copy of the revised CHEC Manual or use the Publication Request Form.

Should you have questions, you may contact Julie Olson, Director, Bureau of Managed Health Care, at 801.538.6303 or JULIEOLSON@utah.gov. ☐

04 - 88 Audiology Manual Correction

The manual listed in error age 20 and older and age 20 and younger with the associated criteria for V5242, hearing aids, analog, monaural. The corrected criteria for code V5242 is the following:

1. **For clients age 18 and older**, the criteria is either:
   a. Average hearing loss in one ear of 35 dB or greater, based on the standard PTA (500, 1000, 2000 hertz) for that ear, or
   b. The recipient is blind and a monaural hearing aid may be contraindicated.
2. **For clients 17 years and younger,** the criteria is either:
   a. Average hearing loss of 30 dBs, based on a high frequency PTA specially calculated for frequencies 1000, 2000, 4000 in both ears; or
   b. The recipient is blind, and a monaural hearing aid may be contraindicated.

The manual listed in error age 20 and older and age 20 and younger with the associated criteria for V5248, hearing aids, analog, binaural. The corrected criteria for code V5248 is the following:

1. **For clients age 18 and older**, the criteria is either:
   a. Average hearing loss in both ears of 30 dB or greater, Based on the standard PTA (5000, 1000, 2000 hertz) in both ears, or
   b. The recipient is blind and a monaural hearing aid may be contraindicated.
2. **For clients 17 years and younger,** the criteria is either:
   a. Average hearing loss of 25 dBs, based on a high frequency PTA specially calculated for frequencies 1000, 2000, 4000 in both ears; or
   b. The recipient is blind, and a monaural hearing aid may be contraindicated

The pure tone average, PTA for adults is the standard PTA calculated from dB loss at 500, 1000, 2000 hertz. The special PTA for children is calculated from the dB loss at 1000, 2000, 4000 hertz. ☐

This bulletin is available in editions for people with disabilities.

Call Medicaid Information:

538-6155

or toll free 1-800-662-9651

04 - 89 Federally Qualified Health Centers and Rural Health Clinics (Correction to MIB 04-60)

Based on clarification from the Centers for Medicare and Medicaid Services, Federally Qualified Health Centers and Rural Health Clinics may be reimbursed for both Health and Behavior Assessment/Intervention codes and any other of the Evaluation and Management services codes when provided on the same day.

Physicians may not be reimbursed for Health and Behavior Assessment/Intervention codes. For health and behavior assessment and/or intervention performed by a physician, see Evaluation and Management services codes. ☐

04 - 90 Attention: Mental Health Centers

Corrections have been made to the Utah Medicaid Provider Manual for Mental Health Centers.
Chapter 1-1, Authority, has been revised for clarity. The section on children in State custody has been moved from Chapter 1-1 to Chapter 1-2. In Chapter 1-3, Definitions, the definitions of diagnostic services and rehabilitative services have been rewritten to better reflect the definitions contained in 42 CFR 440.130. In Chapter 2-3, Mental Health Assessment by a Non-Mental Health Therapist, the limitation on this service has been clarified. In Chapter 2-8, Group Psychotherapy, and Chapter 2-10, Therapeutic Behavioral Services, the qualifications of the group co-leader have been clarified.

Providers will find updated pages with corrections to these chapters. A vertical line in the margin is next to the text that has been changed.

Contact Merrila Erickson at 538-6501 or merickson@utah.gov if you have any questions. ☐

04 - 91 Attention: Substance Abuse Treatment Providers

Revisions have been made to the Utah Medicaid Provider Manual for Substance Abuse Treatment Services. In Chapter 1-3, Definitions, the definitions of diagnostic services and rehabilitative services have been rewritten to better reflect the definitions contained in 42 CFR 440.130. The definition of a substance abuse disorder has also been rewritten to include DSM-IV-TR diagnostic codes. In Chapter 2-3, Alcohol and Drug Assessment by a Non-Mental Health Therapist, the limitation on this service has been clarified. In Chapter 2-8, Group Psychotherapy, and Chapter 2-10, Therapeutic Behavioral Services, the qualifications of the group co-leader have been clarified.

Providers will find updated pages with corrections to these chapters. A vertical line in the margin is next to the text that has been changed.

Contact Merrila Erickson at 538-6501 or merickson@utah.gov if you have any questions. ☐

04 - 92 Attention: Targeted Case Management Providers for the Chronically Mentally Ill, Targeted Case Management Providers for Substance Abuse and Targeted Case Management Providers for the Homeless:

In your provider manuals, item L of Chapter 2-3, item K of Chapter 5-2, and item K of Chapter 2-2, respectively, have been rewritten to clarify that the time spent coordinating between *case management* team members is a non-billable activity.

The section on Shared Case Management has been added back into the provider manuals. See Chapter 2-4, B.; Chapter 5-3, B., and Chapter 2-3, B., respectively.

Targeted Case Management for the Chronically Mentally Ill and Targeted Case Management for the Homeless provider manuals have also been corrected to include a “Limits” and “Units” section. See the updated Chapter 3 in these provider manuals. The Targeted Case Management for Substance Abuse provider manual has also been corrected to include a “Limits” section. See the updated Chapter 6 of this provider manual.

Targeted Case Management for the Chronically Mentally Ill providers only– In Chapter 1-3, Target Group, of the Targeted Case Management for the Chronically Mentally Ill provider manual, the definition of the target group has been updated to specifically reference both serious and persistent mental illness (SPMI) and serious emotional disorders (SED). Also, Appendix 1, which contained "The Utah Scale On The Seriously And Persistently Mentally Ill (SPMI), has been deleted. Providers must ensure that they use the current versions of the Division of Substance Abuse and Mental Health's (DSAMH's) scales for determining SPMI and SED and that clients meet required criteria for receipt of this service.

A vertical line in the margin is next to the text that has been changed.

Contact Merrila Erickson at 538-6501 or merickson@utah.gov if you have any questions. ☐

04 - 93 Medical Supplies

Replacement codes

Y6052, Orthopedic car seat is replaced with T5001, Positioning seat for special orthopedic needs for use in vehicles. Open to ages 0-20 and requires a prior authorization.

K0531LL, Humidifier, is replaced with E0562LL, Humidifier, heated, used with positive airway pressure device.

Opened Codes

K0601, Replacement battery, silver oxide, 1.5 volt, for patient owned ambulatory infusion pump. Limited to three per month and to be used with E0784, external ambulatory infusion pump, insulin.

S1040, Cranial Remodeling orthosis, rigid, with or without soft interface, includes fitting and adjustments.

Corrections

The October 2003 MIB incorrectly listed A6257, transparent film as a closed code. This code is open and can be used.

The January 2004 MIB incorrectly listed E0202, photo therapy light (bilirubin) with an LL Modifier. Please use the RR modifier when billing.

The Medical Supplies Manual has incorrectly required prior authorization for Code A7005, Administration set, with small volume not -filled pneumatic nebulizer, non-disposable. This code does not require a prior authorization.

Wheelchair assessments by Physical and Occupational Therapists.

Wheelchair assessments by PT/OT providers to determine the seating and other medically necessary requirements to the client are reimbursed $200 using code **G9012**, Other case management services not specified. Must be billed by the PT/OT therapist, not the medical supplier.

Prior Authorization Removed

Beginning October 1, 2004 briefs will no longer require a prior authorization. This is for codes: A4525, A4256, A4527, A4528, A4531, A4532, and A4534. Briefs and diapers are limited to 156 per month. Briefts and diapers are covered *for disabled children and adults* only. **Exceptions:** They are not covered for normal infant use nor for adult incontinence not related to a documented medical disability. They are not covered for residents of LTC and ICF-MR facilities. Reimbursement is based on the least expensive disposable diaper available. The amount is limited to a one-month supply or 156 items . If the client is in a waivered program, such as the tech dependent program, and it is medically necessary as determined by their physician, a prior approval may be obtained to override the 156 per month limitation.

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04 - 94 Coding Issues and/or corrections

The July MIB contained two typographical errors:
code 61795 is for stereotactic computer assisted volumetric procedure, not code 61975
code 76872 is for transrectal ultrasound, not code 76820

The code 95807–three stage sleep study is a non-covered code. Inadvertently the professional component of this code was opened and should not be. Noncovered services such as this code require submission of medical record documentation to the utilization committee. Prior authorization may be provided by that committee based on clinical evidence of medical necessity. The code 94772–study of circadian respiratory pattern is only open for infants; individuals over one year of age are not eligible for this service.

Discrepancies were identified between the CPT list and the Hospital Surgical List ICD9 among some of the 5000 codes (59100, 59525, 59851, 59852, 59855, 59856, 59857, 59870) which have been corrected. In addition some non covered codes (21193, 21194, 95990, 99601, 99602) inadvertently dropped from the CPT list as non covered have been replaced on the list.

The following CPT codes have been inadvertently deleted from the list as not a benefit and have been corrected to indicated the codes are covered only for patients age 20 and under
75552 Cardiac magnetic resonance imaging for morphology; without contrast material
LIMITED to patients age 20 and under
75553 . . . with contrast material
LIMITED to patients age 20 and under
75554 Cardiac magnetic resonance imaging for function; with or without morphology; complete study
LIMITED to patients age 20 and under
75555 . . . limited study
LIMITED to patients age 20 and under

The assistant surgeon list was reviewed, the following codes were dropped from the list and will now be covered for an assistant surgeon: 14300, 15750, 15756, 15757, 15758, 15840, 21015, 21344, 21348, 21423, 21435, 21436, 22212, 22222, 23020, 23221, 23900, 24149, 24344, 24346, 24362, 24363, 24802, 26551, 26553, 26554, 26556, 27036, 27158, 27179, 27181, 27259, 27703, 31588, 31775, 33411, 37145, 42420, 43280, 43611, 44204, 44205, 46742, 47701, 48154, 50526, 51800, 54135, 54535, 58540, 61558, 61615, 61616, 67430.
Code inadvertently dropped from list and added 21193.

Correct Coding Initiative
Medicaid has been encouraged by CMS to follow correct coding initiative edits. The correct coding initiative has a group of B status or bundled codes. The editing system includes these Correct Coding Initiative edits which are updated on our system once per year. Many of these codes have already been part of the editing system rebundling or incidental groupings. There are some Medicaid has paid in the past like anesthesia of special circumstance and after hours codes which are no longer reimbursed separately following correct coding initiative guidelines

Codes changed from NonCovered to Covered:
Physician's requested review of coverage of the code 95816 and 95819 for the evaluation and management of seizure disorders. Office procedure codes 95816 and 95819 are limited to physicians and may be billed once on a date of service. The codes 95816 and 95819 are mutually exclusive to each other and to codes 95812 and 95813. Therefore, only one of the four codes will be payable on a date of service.
95816 Electroencephalogram (EEG) including recording awake and drowsy
95819 Electroencephalogram (EEG) including recording awake and asleep
These codes have not been open in the past due to concern for inappropriate use. These codes will be open with periodic utilization review. Multiple EEG tests with the diagnosis of pseudoseizure may be included in this review.

Code changed to comply with HIPAA
The Home Health service code S9122 was paid at a per visit basis which has presented payment difficulty for some agencies. At their request the code description and payment will be changed to follow HIPPA guidelines.

S9122 home health nurse aide/certified nurse assistant visit per hour paid at $18.83 per hour

Payment under this description will be effective October 1, 2004.

Criterion Updates
Added to criterion #10

– With the request for a sterilization procedure which includes hysterectomy, the medical record information must include the results of a recent pap smear, and HCG (Chorionic Gonadotropin) pregnancy test. Patients having a hysterectomy procedure for dysfunctional uterine bleeding must have a TSH (thyroid stimulating hormone) test submitted. Contact the Utilization Review nurse to ensure the necessary tests have been completed prior to submitting the case for committee review. ☐

04 - 95 SECTION I, Chapter 6 - 7, Medicaid as Payment in Full; Billing Patients Prohibited, Revised

SECTION I of the Utah Medicaid Provider Manual: General Information, Chapter 6 - 7, Medicaid as Payment in Full; Billing Patients Prohibited, on page 22, has been revised. The revision removes references to the Primary Care Network Program from the rules regarding the prohibition on billing Medicaid patients. An exception for billing PCN clients is added to the chapter. The on-line version of SECTION 1, on the Medicaid web site http://health.utah.gov/medicaid, includes this revision.

For your convenience, below is the revised text for Chapter 6 - 7. The clarifications are underlined in the text.

6 - 7 Medicaid as Payment in Full; Billing Patients Prohibited

A provider who accepts a patient as a Medicaid or Baby Your Baby patient must accept the Medicaid or state payment as reimbursement in full. A provider who accepts a patient enrolled by Medicaid in a managed care plan must accept the payment from the plan as reimbursement in full. If a patient has both Medicaid and coverage with a responsible third party, do not collect any co-payment usually charged at the time of service. The provider may NOT bill the patient for services covered by either of these programs or a managed care plan. The payment includes any deductible, coinsurance or co-payments required by any other third party, such as insurance or Medicare. Medicaid claim forms and the completion of the claim forms are considered part of the services provided and cannot be charged to Medicaid patients.

The only exceptions to the general rule of accepting the Medicaid payment as reimbursement in full are in Chapter 6-8, Exceptions to Prohibition on Billing Patients. Providers must follow policies and procedures concerning, but not limited to: medical services covered; medical service limitations; medical services not covered; obtaining prior authorization; claim submission; reimbursement; and provider compliance, as set forth in the Medicaid Manuals, Medicaid Information Bulletins, and letters to providers. If a provider does not follow the policies and procedures, the provider may not seek payment from the patient for services not reimbursed by Medicaid. This includes services that may have been covered if the provider had requested and obtained prior authorization.

A provider who fails to follow Medicaid policy and is not reimbursed for services rendered may NOT subsequently bill the Medicaid patient. For example, if the provider submits a request for prior authorization, and the request is denied pending additional documentation, the provider must submit the documentation and obtain authorization, rather than billing the patient for services rendered.

Providers who serve people with a Qualified Medicare Beneficiary Identification (QMB) Card must accept the Medicare payment and the Medicaid payment, if any, for coinsurance and deductible as payment in full. Providers may not bill patients eligible for the Qualified Medicare Beneficiary Program for any balance remaining after the Medicare payment and the QMB coinsurance and deductible payment from Medicaid. (Federal reference: 42 CFR 447.15)

Exception: Effective July 1, 2002, providers who serve Primary Care Network patients may bill patients for non-covered services set forth in the Primary Care Network Manuals, Primary Care Network Information Bulletins, and letters to providers. A written agreement upon time of service is recommended, but not required. ☐